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PRIMARY HEALTH CARE IN NIGERIA: STRATEGIES AND CONSTRAINTS IN IMPLEMENTATION

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ABSTRACT

The Alma Ata declaration on Primary Health Care (PHC) which was made in 1978 is meant to address the main health problems in communities by providing promotive, preventive, curative and rehabilitative services. Nigeria was among the 134 signatories to this invaluable idea. Subsequently, several re-organization of the Nigeria health structure to align with the new vision were made. The implementation of PHC, primarily through services provided at the primary health centres, vary based on the type of PHC facility in Nigeria. Several other PHC services within the health precinct include community mobilization, service integration and selected PHC programmes under the auspices of international collaborators. This review therefore, looks at the strategic trends and constraints in the implementation of PHC in Nigeria since the Alma Ata declaration.

Key Words: Primary Health Care, Strategies for implementation, Constraints, Alma Ata Declaration, Nigeria.

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INTRODUCTION

Primary health care as conceptualized by the Alma Ata declaration of 1978 is a grass-root approach towards universal and equitable health care for all (World Health Organization-United Nations Children Fund, WHO-UNICEF, 1978). The strategy is meant to address the main health problems in the community providing promotive, preventive, curative and rehabilitative services (Olise, 2007). It is the first level of contact of individuals, families and communities with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of the continuing health care process. A primary health centre was described by Maurice King as a unit which provides a family with all the health services, other than those which can only be provided in a hospital (Federal Ministry of Health Nigeria, FMOHN, 2004; Raids, 2008). It fundamentally takes its services outside its own precinct to the homes of people within its jurisdiction. In Nigeria, essentially, three types of primary health centers are recognized within the primary health care system. These include: The Comprehensive Health Centres (CHC); the Primary Health Centres and the Basic Health Clinic (BHC) (Obionu, 2007).

PHC is the latest expression of a belief that can be traced to the 19th century pathologist - Rudolf Virchow, that the solution to major human disease

problems resided not only in the best science available, but also in brave political proposals for social justice and improvements in the life of the poor (McNeely, 2002). Nigeria is one of the signatories to the Alma-Ata declaration of PHC in 1978. But it is interesting to note that prior to the 1978 Alma-Ata declaration, the country had set the ball rolling with the implementation of the Basic Health Services Scheme (1975-1980), which was Nigeria's first serious attempt at the implementation of PHC. This scheme concentrated on the provision of health facilities, training of health workers and paying little attention to community participation, intersectoral cooperation or use of local technology (Obionu, 2007). In 1988, the National health policy of Nigeria was launched and is seen as a collective will of the government and people of Nigeria to provide comprehensive health care system that is based on PHC. The national health policy therefore, describes the goals, structure, strategies and policy direction of the health care delivery system in Nigeria.

In 1992, PHC implementation started with the commencement of PHC programmes in the Local Government Areas (LGAs). Nigeria therefore, became one of the few countries in the developing world to have systematically decentralized the delivery of basic health services through local government administration (Obionu, 2007; Cueto, 2005). In order to ensure the sustainability of PHC in

Nigeria, the Federal Government by decree number 29 of 1992, set up the National Primary Health Care Development Agency. This body was charged with the responsibility to mobilize support nationally and internationally for PHC programme implementation (FMOHN, 2004; Raids, 2008; Magawa, 2012).

STRATEGIES FOR IMPLEMENTATION

The implementation of PHC is primarily through services carried out at the primary health centres and home visits. These services are specifically related to the components. The minimum service components of PHC include education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious disease; prevention and control of locally endemic and epidemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (WHO-UNICEF, 1978). These services are carried out primarily at the primary health care facilities.

As it is in other parts of the world, Nigeria has its own peculiarities characterizing the health care system. These peculiarities are related to her cultural, religious, and sociopolitical diversities. Thus, strategies to implement primary health care must be evolved to meet the challenges associated with these diversities. These strategies include community mobilization and advocacy, service integration, health research, capacity building, and international and non-governmental collaborations.

Community mobilization and advocacy

Community mobilization is the process of arousing the interest of the people and encouraging them to participate actively in finding solutions to their problems (Olise, 2007). It is the gateway to providing effective healthcare services to individuals, families and groups within the communities concerned. Community mobilization engenders community participation and community ownership, and ultimately guarantees sustainability of health programmes (Magawa, 2012). In addition, it enhances resource mobilization, cost minimization and appropriate utilization of health services. Adequate resource mobilization and usage is particularly crucial in resource-poor settings for the implementation of primary health care. Important aspects of community mobilization include community entry, community dialogue, and

advocacy. In community entry, important stakeholders are engaged to obtain necessary permission for health programmes and services, while community dialogue provides opportunity for community members to channel their inputs into the planning, implementation and evaluation processes. Advocacy means providing active verbal support for primary health care by making information available to those who are in a position to act on them. In practical terms, advocacy for primary health care involves communicating the relevance and benefits of PHC to community and opinion leaders, political leaders, policy makers and other important stakeholders.

Beyond verbal support, ordinary community members want to see their leaders patronize and utilize primary health care services. They also want to see health workers including doctors, utilizing PHC facilities for their health needs and that of their families. Community mobilization helps to galvanize support for the development and deployment of primary health care services.

Service integration

Service integration in primary health care has been described as the process of including either the elements of one service or an entire service into the regular functioning of another service (NPHCDA, 2012). It implies providing two or more primary health care services on the same platform by the same team and often simultaneously. This strategy enhances efficiency, prevents duplicity and wastage of resources, and improves availability and accessibility of a wide range of health care services. Service integration is the principle that underlies the Integrated Management of Childhood Illness (IMCI), Integrated Maternal Newborn and Child Health (IMNCH), Maternal Newborn and Child Health Week (MNCHW) and the Immunization Plus Days (IPDs) (Federal Government of Nigeria, FGN, 2007).

Health research

Health research provides a means of systematically identifying health related problems and their determinants so as to evolve ways to solve them. It entails identifying community health needs and their areas of strengths and weakness in order to appropriately deploy and utilize available resources. Efforts have been initiated globally to emphasize the importance of evidence based programming through the application of research findings in policy making processes (Uneke et al, 2010).

Nigeria's National Strategic Health Development Plan (NSHDP 2010-2015) identified Research for Health as a priority area aiming to utilize research for informed policy making and programming, as well as improve health, achieve nationally/international health-related development goals, and contribute to the global knowledge platform. According to the NSHDP, the Government of Nigeria at all levels is expected to invest 1% of her health expenditure (about N6.67Bn) on health research annually (FMOH, 2010). However, a quick review of Nigeria's Federal budget on PHC research as a proportion of PHC budget over the past three years (2011-2013) reveals zero allocation except in 2012 where PHC research formed 0.2% of capital budget (FGN, 2014). In the same vein, the annual budget for most states does not have provision for health research. The implication is that PHC strategic and operational planning has been speculative rather than evidence-based. Therefore, investment in health research is an important and yet neglected strategy for implementing primary health care in Nigeria.

Capacity building

Manpower development is crucial to quality health care delivery. It is required to be a continuous process in order to effectively deal with the constantly evolving health care needs of the people. Primary health care workers and managers need to be trained and retrained on regular basis through workshops, seminars, special courses, and in some cases, in higher degrees. The essence is to maintain a vibrant workforce. Health care workers offering PHC services are no second-class practitioners, and thus must receive government's attention in the area of capacity building.

Non-governmental and international collaborations

The burden of providing health care services to the grass roots need not be borne by government alone. The role of non-governmental organizations (NGOs) has long been recognized in promoting primary health care as noted by the World Federation of Public Health associations (WFPHA, 1978) and continues to be advocated to fill up important gaps (Health Systems Trust, 2013). NGOs and international partners are relevant in supporting PHC programmes with funding, capacity building, operational research and technical assistance. Prominent NGOs and international partners currently supporting PHC services in Nigeria include the Society for Family Health, United Nations Children Fund (UNICEF), Achieving Health Nigeria Initiative

(AHNI), and Pathfinders International among others. These organizations should be encouraged to do more in enhancing primary health care.

CONSTRAINTS TO PRIMARY HEALTH CARE IMPLEMENTATION IN NIGERIA

Though PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts (Abdulraheem et al, 2012). This singular observation points to the shortcomings being experienced in the process of implementing primary health care system in Nigeria. These constraints will be discussed along the planes of governmental/system factors, people/client factors and other factors that are not far between.

The governmental factors include lack of political will; inadequate funding/misappropriation of funds; inadequate inter-sectoral collaboration; and conflicts between Local and State Governments. The people/client factors include community perceptions of poor quality and inadequacy of available services in the PHC centers; under/low utilization of PHC services; and poor community participation. Other factors include lack of motivation in the workplace including poor remuneration; unhealthy rivalry between various categories of health workers; non-involvement of private health sector in the planning and implementation of PHC; and poor management of information system, heavy dependence on initiatives funded by foreign donors like UNICEF and USAID.

Lack of political will

Government commitment has proven to be crucial in the decentralization of health services to improve access to PHC - especially in rural areas (Magawa, 2012). Apart from civil strife, politics can negatively affect the implementation of health programmes (Olise, 2007). Most leaders do not show enough concern for the wellbeing of their citizens. Many of them who will not approve the release of funds for routine health activities will readily endorse/approve any opportunity that will portray them publicly as the champion of the people's cause. There is great emphasis on the construction of gigantic physical structures compared to the provision of good health services which in most instances cannot be measured. Most of the national programmes in Nigeria which are geared towards solving some critical health conditions (like poliomyelitis elimination) only

succeed because of support from external agencies. Unstable leadership is an ill wind. In the last fifteen years, there has been no less than eight Ministers of Health in Nigeria. At the Local Government Area (LGA) level, the headship has also been very erratic. Some of the councils have had three chairmen within a period of twelve months. This high leadership turnover has negative influences in the implementation of PHC services (Adeyemo, 2005).

Inadequate funding/misappropriation of funds

The WHO recommends that at least 5% of GNP should be set aside for health. While the developed nations spend as much as 10% of their GNP on health, developing countries generally spend 1.5 to 4% (Olise, 2007). Inadequate finance and over-dependence of the LGA on federal, state and international agencies for support, because the meager internally generated revenue of the LGA cannot sustain the healthcare services. The financing of (but not the responsibility for) public health is tied to the flow of funds from the federation account. Funds are shared between levels of government according to an allocation formula that keeps about half at the federal level, allocates a quarter to the 36 states, and gives the other quarter to the LGs (Abimbola, 2012; Budget Office of the Federation, 2014).

In a study to examine the management of the Primary Health Care Services in Nigeria using both primary and secondary data, it was found out that the primary health care programme was grossly underfunded and this manifested in the low performance of the PHC facilities (Omoleke, 2005). In poorer nations, funding of health activities is largely from budgetary allocation by the respective levels of government. High personnel cost (70-80%) of the health budget at the grassroots (LGA) level are for settling personal emoluments. Quite often, the workforce is over bloated and many workers can be seen idling away for 70% of the time in their places of work (Olise, 2007). Most health expenditures in the grassroots are from out of pocket expenditures.

Poor inter-sectoral collaboration and conflicts between the Local and State Governments

One of the laid down principles of PHC is intersectoral collaboration but we find out that this is grossly missing in the Nigerian State. Primary health care should be intersectoral, addressing intersectoral determinants in health and involving all other sectors related to the various components. There should be intersectoral collaboration between the health sector

and other sectors such as agriculture, water, industry, education, housing, and works, among others (Obionu, 2007).

Collaborations with other non-governmental organizations (NGO) have resulted in duplication of efforts without proper coordination. There have been instances where two different agencies with varied mission refuse to share information even when the need arises. They therefore increase the workload of the PHC staff that has to source this information for them. Weak support system for PHC is been experienced all over the nation. PHC does not operate in a vacuum. It is part of the National Health System. It therefore, requires the support of other higher levels of care in such areas as training, technical assistance, information and supervision. The secondary health care provides the immediate back-up services including referral support. Where the two-way referral system is weak or the other levels of care are in a state of decay as in many poor countries, primary health care also suffers.

Health services in Nigeria mirror political organization. The federal government is responsible for tertiary care, state governments for secondary care, and the local governments run primary care. The financing of public health is tied to the flow of funds from the federation account. Funds are shared between levels of government according to an allocation formula that keeps about half at the federal level, allocates a quarter to the 36 states, and gives the other quarter to the LGs. These resources are not sectorally earmarked and the States and Local Governments are not constitutionally required to provide budget and expenditure reports to the federal government. Nigeria thus leaves the most important and consequential level of health care – primary health care – to the weakest level of government. This results in poor coordination and integration between levels of care, giving rise to a weak and disorganized health system, in which widely varying patterns of outcomes depend on local situations (Abimbola, 2012).

Community perceptions of poor quality of services at PHC facilities

Perception influences acceptance which in turn determines utilization. Most Nigerians have a wrong perception about PHC. Little wonder individuals would prefer to queue up in a teaching hospital for treatment of common ailment such as malaria, wasting resources and time instead of visiting a PHC facility closer to them where they can get some level of care.

Such perceptions include the belief that PHC is meant for the rural poor which inputs the mentality that the services are meant for lower class citizens. In addition, health workers in PHC facilities, apart from being insufficient are perceived to be less qualified when compared to their counterparts in tertiary health facilities. Others include the view that PHC is an avenue for diversion and misappropriation of funds by the Local Government officials and that free health care services available in the facilities are of poor quality.

Inadequate community participation

Utilization of services depends strongly on community ownership which comes through community participation. Alma-Ata declaration identified community participation as the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their community development (WHO-UNICEF, 1978). Community participation is the hall mark of primary health care, without which it will not succeed. It is a process by which individuals and family assume responsibility for their own health and those of the community and develop the capacity to contribute to their/and the community development. Participation can be in the area of identification of needs or during implementation. The community needs to participate at village, ward, district or local government level. Community participation has been apparently institutionalized through the formation and creation of Village Development Committees (VDC) and Ward Development Committees (WDC). Some of these committees which were formed to improve the workings of PHC at the grass-roots have been turned around and are now either non-functional or are being used for other purposes such as being politics. The expected mutual support from the community and government has broken down in recent times. Inadequate community mobilization and advocacy are some of the reasons for poor community participation.

Problem with human resources for health

No health system can function effectively without an effective workforce. As a matter of fact human resources form the pillar of every health system. Unfortunately, the implementation of PHC in Nigeria has met with a number of problems relating to health manpower. These problems range from inadequacy of personnel, inequitable distribution of available personnel, inter-cadre conflicts, poor job satisfaction,

and paucity of accurate data on the available staff (Health Reform Foundation of Nigeria, HERFON, 2009; Abdulraheem, 2012). The problem of human resources in Nigeria is further worsened by lack of planning. In some other instances where recruitment of skilled manpower is achieved there have been reported failures in the interpretation of their job descriptions. Several cases have been reported by the Nigerian Medical Association (NMA) concerning some states in which Medical Officers are denied the headship of the PHC departments even after they have been employed into the services of the Local Government.

Other factors implicated in the difficulties being experienced in primary health care implementation in Nigeria are mismanagement of resources such as project vehicles, generators and other equipment to the detriment of planned programmes. Such issues as pilfering of drugs and poor maintenance of equipment as indicated by Wunsch et al (1996) contribute significantly to the constraints.

Conclusion and Recommendations

In the Nigerian environment, as it is in many developing countries in Africa, the implementation of primary health care is still faced with many challenges. The following points may be useful in overcoming some of these identified constraints.

1. Government at all levels in Nigeria should be charged to re-orient prospective political office holders on the importance of the health of her citizens, especially pregnant women and children under the age of five years and the current classification of countries based on its health indices.
2. The Federal Government should be encouraged to bring together all the foreign donor agencies and UN agencies to ensure that comprehensive PHC is practiced as against the selective PHC concept with its attendant draw backs
3. Health education should be carried out at all levels by the Federal Government for a proper understanding of the real meaning of primary health care and the usefulness of community participation in its implementation.
4. The Legislative arm of government should ensure that the right bills- for example the national health bill which empowers the employment of more qualified health personnel at the primary health care

facilities, is passed into law and fully implemented.

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AUTHORS' CONTRIBUTION

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